



REFORMING CHILDREN'S MENTAL HEALTH SERVICES IN MISSOURI

**A Comprehensive Children's Plan
in response to Senate Bill 1003**

*"Missouri's children will receive the mental
health services and supports they need."*

December 2004

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REFORMING CHILDREN’S MENTAL HEALTH SERVICES IN MISSOURI

“Missouri’s children will receive the mental health services and supports they need”

EXECUTIVE SUMMARY

State policymakers, families, and practitioners are increasingly concerned about the mental health needs of children in Missouri. Providing appropriate and effective services to meet their needs is a high priority. Senate Bill 1003 was enacted into law in 2004 to require the development of a unified, comprehensive plan for children’s mental health services. When fully implemented, this plan will ensure that all of Missouri’s children receive the mental health services and supports they need through a comprehensive, seamless system that delivers services at the local level and recognizes that children and their families come first. Missouri’s mental health services system for children will be accessible, culturally competent, and flexible enough to meet individual and family needs; and family-centered and focused on attaining positive outcomes for all children.

This plan for a comprehensive mental health system for children builds on years of work to address the mental health needs of Missouri’s children. The plan also continues to address a tragic consequence of the current system that sometimes results in families relinquishing custody of their child for the purpose of accessing needed mental health services. This is a decision no family should be forced to make. Senate Bill 923 enacted in 2002 and Senate Bill 266 enacted in 2003 gave rise to policies aimed at stopping this terrible dilemma. As a result of Senate Bill 923, protocols were developed to divert children from having to be placed in state custody for the sole purpose of mental health treatment. These protocols are being established statewide. Senate Bill 266 called on the state to identify those children in state custody for mental health treatment only and return those children to the custody of their family when appropriate. This process currently is being implemented. The system of care mandated by Senate Bill 1003 will further refine and incorporate the work of the previous legislation to ensure that relinquishing custody is never an option to be considered for accessing the children’s mental health system in Missouri. Information on the status of these efforts is provided in the *Status of Reform*, which is under Tab 6.

Under Senate Bill 1003, all the diverse interests in children’s mental health are brought together with a mandate to develop and implement a comprehensive children’s mental health service system. The plan that follows in this report is not a Department of Mental Health plan to address children’s mental illness, but rather it is a state plan for a full spectrum of services and supports needed to provide for the mental health of

all children in Missouri. To that end, the plan focuses on prevention, early identification and intervention as well as the community-based treatment and hospitalization services that are needed in a comprehensive system.

Public Health Model:

The comprehensive plan presented in this report will use as its foundation a public health approach to meeting the mental health needs of children. The public health model emphasizes the necessity of health promotion and prevention as a part of the full spectrum of services. This is a departure from the medical model used in Missouri and most other states. The public health model presented in this plan consists of three components:

- **Surveillance and assessment of mental health** needs, including risk factors, demographics, access in care, and rates of disease;
- **Policy development**, including financing, inter-agency collaboration, and policy initiatives; and
- **Service delivery system**, providing services that are evidence-based and organized by developmental stages through a matrix of services, health promotion, quality, access to care, and evaluation and monitoring.

Recommendations:

Development of the comprehensive statewide system will include changes in state policies, financing mechanisms, training and other support structures; changes at the state and local level to plan, implement, manage and evaluate the system; and changes at the service delivery level to ensure quality prevention and treatment services and supports.

The recommendations for accomplishing these changes and implementing the comprehensive system using the public health model are included under Tab 4 of this report. A table listing the recommendations and short-term and long-term goals for each recommendation is under Tab 5. Recommendations are summarized around the following areas:

Assess mental health service needs statewide

- Develop capacity to gather and compile data across multiple agencies;
- Assess risk and protective factors at the local level

Policy development

- Partner agencies will establish collaborative policies to support key system components
- Create governance structure across state departments at the Director level
- An interagency Comprehensive System Management Team (CSMT) will operationalize policies
- Establish local management structure
- Ensure family involvement at all levels of administrative structure

- Ensure sufficient and flexible funding to support system

Service Delivery System

- Ensure early screening
- Make education, information and outreach available to families
- Children with identified needs will have an Individualized Plan of Care (IPC)
- A full array of evidence-based services and supports, from prevention, to treatment, to follow-up, will be available in all areas of the state
- Appropriate training on the comprehensive system will be provided at all levels
- A system evaluation and monitoring process will be established

Financing the System:

Developing and implementing the Comprehensive Children's Mental Health Services System will require the development of resources and the shifting of resources.

Proposals to address the priorities of the system are included in the Department of Mental Health budget request for Fiscal Year 2006. Some of the requests focus on DMH programs, but others are not items that are specific to DMH, but represent critical issues in the implementation of the Comprehensive Children's Mental Health Service System that cut across multiple public child serving agencies. The items include strategies found in the budget requests of other agencies, with DMH supporting the request. In most cases, these items build on past work. These issues addressed in the DMH budget include:

- Early Childhood
- School Based Services
- Prevention
- Relinquishing Custody
- Mentally Ill Juvenile Offenders
- Federal Grants

Implementation Timeline:

The plan will be implemented in three phases over a five-year period:

- Planning and transition (FY 2005 – FY 2006);
- Capacity and infrastructure building (FY 2007 – FY 2008);
- Continue capacity building and system refinement (FY 2009 – 2010).

THE CALL FOR REFORM

“Growing numbers of children are suffering needlessly because their emotional, behavioral, and development needs are not being met by those very institutions which were explicitly created to take care of them.”

—U.S. Surgeon General’s Conference on Children’s Mental Health (2000)

Background

An effective children’s mental health services system in Missouri is a key element in the overall health and safety of the state. An effective system is crucial for thousands of children to realize success at home, at school and in their communities. Reforming the current children’s mental health system represents a sound investment in the future.

The passage of Senate Bill 1003 in March of 2004 continues to focus attention on this reform. This landmark legislation provides a clear direction for the future, while building on previous and ongoing efforts to improve this critically needed and very complex system of care.

The call for reform began with the parents and families that use the system. Motivated by a desire to ease the personal pain and challenges these families face has brought advocates, services providers and policymakers together to address this complex issue. Foremost among the challenges faced by families under the current system is a lack of access to treatment for their children. A horrible reality of the current system is that sometimes parents relinquish custody of their child for the sole purpose of accessing the needed mental health care. Usually, these families do not qualify for Medicaid and have exhausted all of their private health insurance for their child’s mental health care. Relinquishing custody to the state is their last hope. This terrible dilemma has fueled the drive for reform in Missouri.

Citizens for Missouri’s Children (CMC), a statewide children advocacy and policy organization, brought this situation to light in Missouri with a 2002 report. The CMC report followed up on a national report on the issue by the Bazelon Center for Mental Health Law.

Exposing the issue of relinquishing custody helped initiate the current efforts at reform. Legislation to exclude parents from placement on the abuse and neglect registry when they relinquish custody for mental health care only was passed in 2002. The Children’s Division (CD) and the Department of Mental Health (DMH) established a process to divert children from ever having to be placed in state custody to receive mental health care. The following year legislation was passed to require the state to identify those children already in state custody for mental health care only and to return those children to the custody of their parents when appropriate. Senate Bill

1003 builds on this progress and brings together the varied programs and policies on children's mental health needs into a seamless, comprehensive system.

The Growing Need

Childhood mental illness can be debilitating and can seriously impact the quality of a child and family's life. The U.S. Surgeon General's 2000 Report on Mental Health reported that almost 21 percent of children ages 9-17 have a diagnosable mental or addictive disorder associated with at least minimum impairment. Also, an estimated 11 percent of children ages 9-17 suffer from a major mental illness that results in significant impairments at home, at school and with peers.

Children with mental health needs are more likely to have trouble at school and more likely to become involved with the juvenile justice system. Nationally, 48 percent of students with serious emotional disturbances drop out of high school compared with 24 percent of all high school students. Of those students with a serious emotional disturbance (SED) who drop out of school, 73 percent are arrested within five years of leaving school. (U.S. Department of Education) School failure contributes to truancy, inability to work productively as adults, and a greater risk of involvement with the correctional or juvenile justice system (DMH Strategic Plan).

A high percentage of youth involved with the juvenile justice system have mental health needs. A survey of 1,450 Missouri youth detained in the juvenile justice system showed that 32 percent reported a history of previous mental health services; 18 percent reported being prescribed some type of psychotropic medications; and 10.4 percent of youth were prescribed more than one psychotropic medication (MO MAYSI PROJECT REPORT, 2003).

At any given time during 2000, the Division of Family Services (now the Children's Division) had over 12,000 children in out-of-home placement. It was estimated that approximately 2,000 of these children had a serious emotional disturbance. The joint DMH and DSS report to the Governor in response to SB266 estimated that approximately 600 children may be currently in the child welfare system, not because of abuse or neglect issues, but because of the need for mental health care. (Smith, 2004)

The growing need for mental health services continues to strain the limited resources of the system. Most of the resources available under the current system target the needs of the most serious cases. Few resources are directed to prevention and early intervention activities

The Current System

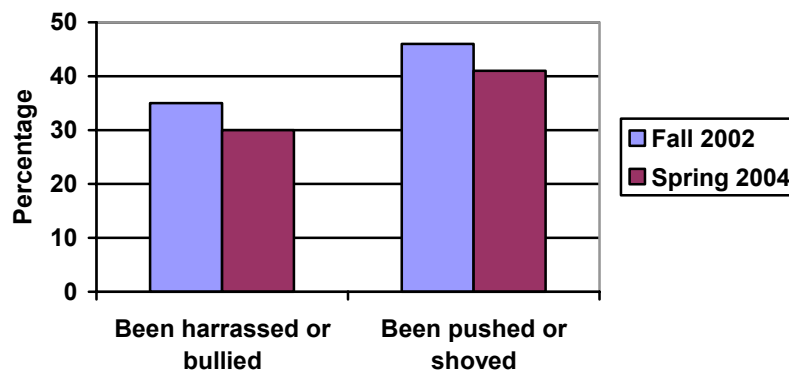
Presently the children's mental health system can point to successful programs such as the partnership between the Department of Mental Health (DMH) and the courts to identify and provide for the mental health needs of youth in the Juvenile Justice system. Through a collaborative agreement between DMH and the Department of

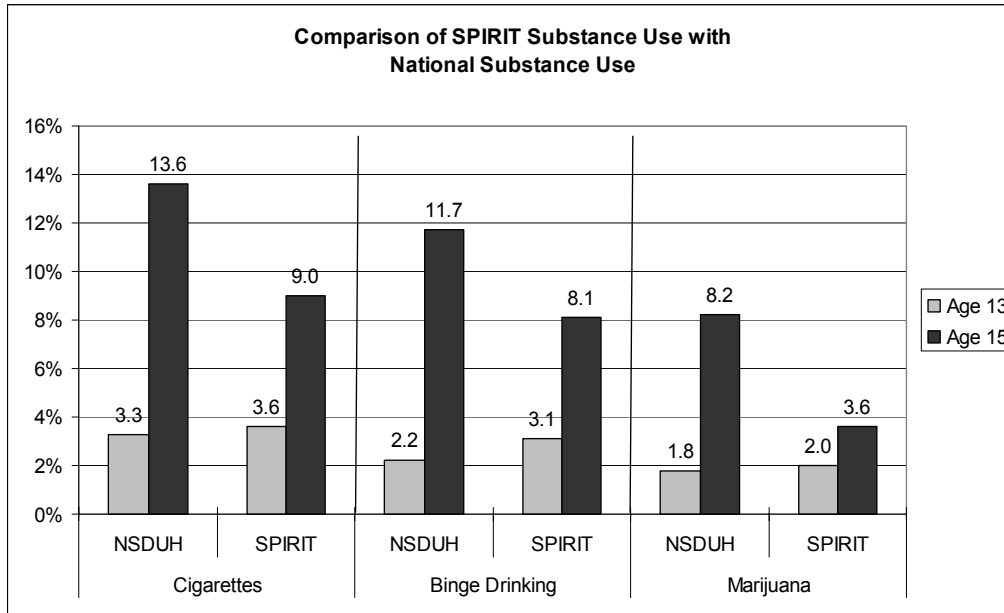
Social Services, efforts are in place in several areas of the state to more effectively meet the needs of children in the custody of the Children's Division who are placed in highly restrictive levels of residential care.

The Department of Mental Health, in partnership with other child serving entities, has helped develop local community-based services for children with serious mental health needs and their families. Federal grants have helped to establish an integrated, inter-agency, community-based "System of Care" in the following areas: Adair County; St. Louis City and St. Louis County; Jackson County; St. Charles County; St. Francois County; and Butler and Ripley counties. Recently, the state was awarded a six-year federal grant from the Substance Abuse and Mental Health Administration to support system of care development in the southwestern counties of Greene, Christian, Taney, Stone, Barry and Lawrence.

Prevention activities include the implementation of evidence-based practices to reduce the risk of substance abuse in five local Missouri school districts through the Division of Alcohol and Drug Abuse's S.P.I.R.I.T initiative. The charts below show current SPIRIT outcomes for bullying in middle school and alcohol and other drug use (compared with national sample).

Percentage of middle-school students reporting harassment or bullying behavior





“The current child mental health service system in Missouri involves multiple state departments. Without defined leadership, coordination, and dedicated funding, the system is not as efficient and effective as it can be in achieving successful outcomes for children.”

—*Children’s Mental Health Advocates (2004)*

Despite the success of these and other initiatives, the current children’s mental health services system in Missouri is fragmented among multiple state departments. This fragmented and inadequate system can inadvertently cause parents to give up custody of their child to the state in order to secure necessary mental health care for their child.

The Bazelon Center for Mental Health Law reports that relinquishing custody to receive mental health care is a national problem. In at least 10 states, almost one in four families considers choosing between getting mental health treatment for their child and retaining legal custody of the child. As noted earlier, an estimated 600 children may be in the custody of the child welfare system solely to receive mental health services. They were not placed due to child abuse, neglect or abandonment. This tragic dilemma, more than any other factor, stirred the effort now underway to reform the children’s mental health system in Missouri.

A consistent underlying theme in describing the current system is one of limited resources and uneven allocation (Smith, 2004; Workgroup 1). While all of Missouri’s child-serving state departments provide some form of mental health services along the prevention, early intervention, and direct service continuum, a lack of resources severely affects both access to the system and the capacity of the system to provide necessary services. Some services are available statewide, however most services are

limited due to issues of capacity, geography, and/or narrow eligibility criteria. Access to mental health services for children is, in part, dependent upon where the need is identified, by the system the identifier is in, and the diagnosis itself. Much of the current system is organized around the provision of high intensity, highly restrictive treatment services even though there is little or no evidence that the current practice is effective at meeting the needs of children and families or the most effective use of limited state and federal resources.

The impact of resource availability and allocation on children's mental health services was one of the areas examined in an in-depth review of the current system. A workgroup studied and reported on the components of the current system. The trends identified by this workgroup are consistent with national findings around five key areas:

- prevention/early intervention
Many state agencies and community providers offer some type of prevention or early intervention services. However, access and capacity across the state varies significantly in almost all programming. This is in part due to funding priorities for many community and state agencies.
- child and family supports
There appears to be an increased recognition of the needs of families to help them access support services with some increase in available supports. However, there is not a consistent philosophy for supporting families across the system, as well as a lack of funding and capacity.
- treatment and rehabilitation
There are examples of successful programs in Missouri, such as Division of Youth Services (DYS) program for juvenile offenders; CSTAR program for substance abuse treatment; therapeutic foster care; and wrap around services. There needs to be better collaboration among the state agencies involved and the state needs to expand its ability to fund these effective programs.
- special populations
Early childhood, youth involved with the juvenile justice system, and youth with co-occurring disorders are some of the populations that require greater levels of interagency collaboration and are in need of more attention. The system, at the same time, is not able to fully meet the needs of the more traditional populations of youth with a serious emotional disturbance and youth with developmental disorders.
- system administration
In the past year there has been a growing level of collaboration across state departments and systems that serve children. One of the major barriers to more effective collaboration is the diversity of departments' organizational

structures. Some are very centrally driven, others rely heavily on provider networks, and others are more locally driven. The ability to collaborate, communicate, influence practice at the local level and set policy is impacted by this structural diversity.

The report of the workgroup shows the strengths and weaknesses of the current system and establishes the baseline for the implementation of the comprehensive system. The findings of the workgroup are available as a separate report under the cover of “Current Mental Health Services.”

Legislation

Energized by the tireless efforts of parents and child advocates, the Governor and Legislature began enacting legislation in 2002 to improve the child mental health system and to specifically address the issue of parents relinquishing custody.

Senate Bill 923, passed and signed into law in 2002, started the current process to correct through legislation the flaws in the system. Under the changes made by the bill:

- A family may now seek assistance from the court to obtain mental health services without being placed on the child abuse and neglect register;
- Juvenile courts now have jurisdiction in cases of children in need of mental health services, whose parent, guardian or custodian is unable to afford or access appropriate mental health treatment or care for the child;
- Juvenile courts may now order that the child receive necessary services in the least restrictive environment, including home and community-based mental health services, treatment and supports. That order must be based on a treatment plan developed by the state agencies responsible for providing and paying for the services.

Senate Bill 266, enacted in 2003, continued the effort of children’s mental health reform. The bill focused on identifying children in state custody for mental health needs only. The bill required the Department of Mental Health and Department of Social Services to jointly prepare a plan to address the need for mental health services and supports for all cases in the custody of the Department of Social Services that involve children in the system due exclusively to a need for mental health services, and where there is no instance of abuse, neglect or abandonment.

This requirement led to the identification of an estimated 600 children who might be in state custody of the child welfare system solely to receive mental health care.

Sweeping reform for children’s mental health took place in 2004 with the passage of **Senate Bill 1003**. The changes called for in this bill evolved from the work of the Children’s Services Commission, an entity created in 1983 by state statute 210.101. The

Children's Services Commission represents all three branches of government and the private sector. The commission takes a leadership role in identifying and evaluating current programs and makes recommendations to the state.

A special subcommittee of the Children's Services Commission was formed to look at reforming the child mental health service delivery system. The subcommittee's 2003 report recommended statutory language to establish the comprehensive children's mental health service system. Senate Bill 1003 became the legislative vehicle for this language and was the first bill passed by the Legislature and signed by the Governor in the 2004 session.

SB 1003 requires that the state have a Comprehensive Children's Mental Health Services System and that the Department of Mental Health, in partnership with other state agencies, develop a plan for the system. The plan was submitted to the Governor and General Assembly in December, 2004.

Senate Bill 1003 also expands Senate Bill 266 by requiring Children's Division to determine which children are in their custody solely due to mental health needs. Within 60 days of identifying these children, appropriate agencies and the family must develop an individualized services plan for each child, identifying which agencies will provide and pay for services, subject to appropriations. The plan must be submitted to the court for approval.

After the court approves a plan, the court may order the child returned to the custody of their parent, guardian, or custodian. This section of the legislation is intended to get children back into the custody of their families as soon as possible.

Finally, the bill creates a new funding relationship between the Department of Mental Health and the Children's Division. After children return to the custody of their family and are being served by DMH, DMH can bill the Children's Division for the cost of care pursuant to the individualized service plan and the comprehensive financing agreement made by the two agencies.

House Bill 1453 was also enacted in 2004. This bill made major reforms in the state foster care system. The legislation included provisions authorizing the Department of Social Services to enter into "voluntary placement agreements" with parents, legal guardians or custodians for placement and of children who only need mental health services. The parents, legal guardian or custodian would retain legal custody. This is another effort to avoid the relinquishing of custody for mental health care.

Developing the Plan

Developing the plan for the comprehensive system began almost immediately after Senate Bill 1003 was signed into law. Language in the bill called for the formation of a Comprehensive System Management Team to establish the system detailed by the plan. Members of this team can be found in under Tab 7. The bill also required a

Stakeholders Advisory Committee to provide input to the management team and ensure positive outcomes for children are being achieved. Members of this committee can also be found in under Tab 7.

The language in Senate Bill 1003 detailed the agencies and other groups that must be represented in the new system. The language also was very detailed about the components that must be included in the plan. The Stakeholders Advisory Committee, in conjunction with the Department of Mental Health, led the plan development process. Work groups representing all the interested parties in children's mental health issues were formed to develop the plan, based on the requirements set forth in Senate Bill 1003. The work groups are listed below.

- **Current Mental Health Services Workgroup** described the current mental health service system for Missouri's children and their families, including the specialized services for specific segments of the population. The group described the gaps in services, as well as the service needs.
- **Ideal Comprehensive Services Array Workgroup** described the ideal array of services including services such as intensive home-based services, early intervention services, family support services, respite services, and behavioral assistance services. The group looked at ways to finance the implementation of the complete array of services. In addition, the group looked at ways to evaluate the effectiveness of the system and identify the training needed.
- **Ideal Administrative and Services Structure Workgroup** described the ideal structure for the administrative function and service system, based on principles defined in the legislation. The structure should allow for providing services at the local level; involving the family and local schools; coordination of services across child serving agencies and providers; payment methods; and the roles and responsibilities of the state and local agencies that are part of the system.
- **Implementation of Child Welfare/Mental Health Reform Workgroup** is responsible for monitoring the implementation of the reforms and requirements of Senate Bill 923 (2002); Senate Bill 266 (2003); and Senate Bill 1003 (2004). The group's status report on the legislation is included in this report.

The workgroups met throughout the summer and their products were compiled as the core of the Comprehensive Children's Mental Health Services System Plan.

COMPREHENSIVE CHILDREN’S MENTAL HEALTH SERVICES SYSTEM PLAN: ASSURING THAT MISSOURI’S CHILDREN AND FAMILIES RECEIVE THE MENTAL HEALTH SERVICES AND SUPPORTS THEY NEED

“To improve the system, it will be necessary to look beyond who is already in the system to the greater population and seeing care happen on a broader continuum that begins with health promotion and illness prevention, includes treatment and supports the process of recovery throughout.”

—National Association of State Mental Health Program Directors (2004)

Plan Overview

The Comprehensive Children’s Mental Health Plan provides a description of how Missouri’s publicly funded child serving agencies, working in partnership with families, advocates and providers will improve the delivery of mental health services and supports. While the system proposed in the Plan would be impossible without Missouri’s long history of successful collaborations, the proposed comprehensive system moves beyond fixing any one particular systemic problem. The Plan presented in this document represents a major transformation both in who is served as well as how services are delivered.

Organization of the Plan

The Comprehensive Children’s Mental Health Plan outlines the specific features of a children’s mental health system. It describes the overarching mission, principles and goals of the system as a whole; the rationale underlying reform and components of the system; necessary infrastructure and financing to support the system; and finally outlines a vision for the future. Building on past work, key areas of the system are described; priority components are targeted for immediate implementation while other system components identified will be incorporated into the Plan as they are developed. The Plan provides a guide and organizing framework for reforming how “Missouri’s children will receive the public mental health services and supports they need.”

Vision and Fundamental Principles of the comprehensive system

The **major goal**/vision of the Stakeholders Advisory Group and, therefore, this Plan is that:

“Every child who needs mental health services and supports from the public mental health system will receive them through a comprehensive, seamless system that

delivers services at the local level and recognizes that children and their families come first. Missouri's public mental health services system for children shall be easily accessible, culturally competent, and flexible to individual needs, accountable to those it serves, and shall result in positive outcomes for children and families."

The following **principles of practice** guide the system and were established by the legislature as part of the Comprehensive Children's Mental Health Act. The Comprehensive Children's Mental Health System shall:

- Be child centered, family focused, strength-based, and family driven, with the needs of the child and family dictating the types and mix of services provided, and shall include the families as full participants in all aspects of the planning and delivery of services;
- Provide community-based mental health services to children and their families in the context in which the children live and attend school;
- Respond in a culturally appropriate and competent manner;
- Emphasize prevention, early identification and intervention;
- Include early screening and prompt intervention and assure access to a continuum of services;
- Assure a smooth transition from child to adult mental health services;
- Coordinate a service delivery system inclusive of services, providers, and schools;
- Be outcome based; and
- Address unique problems of paying for mental health services for children and assure funding follows children across service delivery systems.

Common goals, values, and set of operating principles are critical if a population-based, as opposed to diagnosis-based, approach is to be effective in accomplishing its objectives. The goals and values must be shared by all stakeholders; including the executive, legislative and judicial branches of government; mental and behavioral health agency staff; parents; children's services providers; and communities. Developing and maintaining goals and values that everyone can agree to have historically been impeded by fragmented systems, differing missions, and perceived differences in perspectives; yet, on the other hand, all systems share the common principle that the welfare of the child is of utmost importance. The above **principles of practice** are not meant to replace any specific system's mission or values; they do provide the organizing philosophy and guidelines that underlie the proposed public mental health service delivery approach.

While the Plan specifically addresses the public mental health system, many children receive mental health services through various private service options. Although the vast private mental health service sector is beyond the scope of the SB1003 legislation, the Department of Mental Health acknowledges the importance of alignment with and fostering integration across the public and private systems.

Therefore the department will work to interface with leaders within the private sector as the system is implemented.

The foundation for improving the system will be moving away from the medical model used in Missouri and most states and adopting a public health approach to the mental health needs of Missouri's children and youth as called for in the President's New Freedom Commission on Mental Health.

Desired System Results

The transformation of the children's mental health system from one heavily focused on those with severe emotional disturbances to one focusing on promoting and sustaining mental health and providing appropriate care along the continuum of need will yield the following results.

- All of Missouri's children will receive the mental health services they need through a comprehensive, seamless system that delivers services at the local level and recognizes that children and their families come first.
- Missouri's mental health services system for children will be easily accessible, culturally competent, flexible and adaptable to individual needs, and result in positive outcomes for the children and families it serves.
- No parent will have to relinquish custody of their child solely in order to access needed mental health services.
- Any child in Missouri can be screened for mental health needs at the first sign, request of a parent, or a child serving entity; and screening for mental and behavioral health will be a routine practice for all pediatric health care providers.
- Education and information on promoting mental health, risks and signs of mental illness, where to get help, information about their child's illness and availability of support and outreach to families and communities will be available.
- Missouri's state child-serving agencies will have the ability to share data across multiple agencies permitting joint quality decision making about patterns of care, service needs, quality and cost effectiveness.
- Mechanisms for comprehensive, integrated system governance and management will be established at the state level and will reflect the cultural diversity of Missouri and will be inclusive of families and youth.
- A broad-based Stakeholder Advisory Group with at least 51% family representation will provide ongoing input into system design, implementation and evaluation.
- Sufficient and flexible funding will be available to promote a more efficient system of prevention activities, services and supports.

- An Individualized Plan of Care and care coordination will be available to all children, as needed.
- All children and families will have access to the appropriate level and mix of individual and community support representatives and professional staff who join together to support the family and ensure implementation of a cohesive Individualized Plan of Care.
- A local system in which agencies, providers and practitioners coordinate care with one another, with other systems and with community leaders in addition to representatives of families and youth will be available.
- All areas of the state will have available an array of services addressing prevention and treatment, and ensuring a smooth transition to adult services when necessary; services will be based on effective and evidence-based programs and practices.
- The system will have the ability to respond to the unique needs of children within special populations including but not limited to autism, co-occurring behavioral and substance abuse and/or developmental disabilities, effects of experiencing trauma and other populations, including racial and ethnic minorities that are particularly at risk or have special service or access needs.
- The system will have a plan for creating adequate numbers of appropriately trained, and culturally competent, behavioral health care staff who are appropriately distributed across the state.
- Implementation of a statewide process for measuring the effectiveness of services and supports and that ensures the system is operating in accordance with its operating principles.

System development phases

Development of the proposed comprehensive statewide system is a multifaceted, multilevel process (Stroul, 2002), which includes:

- Changes in state policies, financing mechanisms, training, and other structures and processes to support the system;
- Changes at both the state and local level to plan, implement, manage, and evaluate the system; and
- Changes at the service delivery level to provide a broad array of effective, evidence-based prevention and treatment services and supports to children and families in an individualized and coordinated manner.

Comprehensive reform of the children's mental health service system must be a progressive but incremental process. Historically, responsibility for children's mental health services has not resided in any one state agency: each child- and family-serving agency has had its own policies and procedures. This, in part, led to the enactment of SB 1003. In order to bring these multiple components into a

coordinated and comprehensive system, considerable assessments and discussions will be required. The very fact that families had to relinquish custody in order to get the care that their children required and deserved is reflective of the fragmented growth of Missouri's children's mental health service system. The components of a comprehensive system are interrelated and, therefore, an effective system must be able to harmonize the elements of the system, across existing systems and agencies. Under the best of circumstances, effective system reform takes several years. Reform of a system affecting some of Missouri's most vulnerable populations must be focused and implemented in a progressive and timely manner. Reformation of the children's mental health services system will require significant changes in program development, implementation of new administrative structures and collaborative arrangements, financing strategies, and major workforce development efforts.

The Stakeholder Advisory Committee workgroups established in response to SB 1003 began the work of defining what is needed to transform the system. The Plan that follows represents this work but should also be considered as a living, evolving document that changes over time to meet the needs of the maturing system. To reflect the complexities involved in this level of change and the planned stages of development, the implementation is phased over five years.

1. Planning and transition (FY2005-2006) began with the signing of SB1003 and the meetings of the Stakeholder Advisory Committee and its workgroups throughout the summer in order to conceptualize and plan for the system. Planning activities will continue with broad-based input from stakeholders to address short-term goals and objectives in the Plan. Transition activities include: implementing statewide protocols designed to address the needs of children at risk of entering the custody of the Children's Division solely to access needed mental health services; returning children already placed in Children's Division custody to the custody of their families when possible; changes in identified funding streams including Medicaid and Title IV to support these efforts; and testing of a service quality review practice for statewide implementation. Education of partner agency staff, families and the public on the system is also a priority for this phase (see Part IV: Status of Reform for additional information).
2. Capacity and Infrastructure building (FY2006-2008) will focus on both expanding service capacity and creating the infrastructure to support the system. Service capacity expansion will focus on priorities targeted in the Plan, workforce enhancement, and developing an approach to ensure services implemented are research-based and include the essential elements of care coordination and methods for individual care planning. Areas of focus for infrastructure development include: formalizing interagency management structures at both the local and state levels; continued identification of more

effective ways of combining and maximizing multiple funding sources and mechanisms; implementation of a quality review process statewide; and developing a capacity to collect data on children served across all systems.

3. Continued Capacity building and system refinement (FY2008-2010) will utilize the information received from the quality service review process and integrated data collection regarding the maturing system to make any adjustments necessary. Changes identified to funding streams will be finalized and a mechanism for seeking new funding opportunities established. Service expansion with corresponding workforce development will continue with a mechanism established for ongoing workforce enhancement.

Foundation of the Integrated System: a Public Health Approach

Missouri is not alone in its concern for the mental health needs of its children. At the first ever U. S. Surgeon General's Conference on Children's Mental Health in 2000, the Surgeon General reported "growing numbers of children are suffering needlessly because their emotional, behavioral, and development needs are not being met by those very institutions which were explicitly created to take care of them." The National Advisory Mental Health Councils' Workgroup on Child and Adolescent Mental Health concluded its review by reporting "no other illnesses damage so many children so seriously." In July 2003, the President's New Freedom Commission on Mental Health released its report that both recognized the nation's current mental health system as a "patchwork relic" and recommended a fundamental transformation of the nation's approach to mental health care. Identifying the current situation as a "public health crisis" the report concludes that "the extent, severity, and far-reaching consequences of mental health problems in children and adolescents make it imperative that our nation adopt a comprehensive, systematic, public health approach to improving the mental health status of children."

The New Freedom Commission report advances a vision for children's mental health that promotes the emotional well-being of children and provides access to comprehensive, home and community-based, family-centered services with supports for children with mental health disorders and their families. This vision includes a call for creating conditions that promote positive mental health and emotional well-being and prevent the onset of emotional problems in all children.

The Report from the President's New Freedom Commission on Mental Health as well as the earlier reports helped inform the development of Missouri's Plan.

While there are pockets of excellent mental health services, the stakeholders of this system readily agree that the system as a whole is neither as effective nor as

efficient as it can be. The foundation for improving the system will be moving away from the medical model used in Missouri and most states and adopting a public health approach to the mental health needs of Missouri's children and youth as called for in the President's New Freedom Commission on Mental Health.

The current medical model emphasizes service or treatment based on diagnosis. In order to improve access and availability, and quality and appropriateness, it will be necessary to "look beyond who is already in the system to the greater population and seeing care happen on a broader continuum that begins with health promotion and illness prevention, includes treatment, and supports the process of recovery throughout" (NASMHPD, 2004). With its strong emphasis on prevention, early identification and intervention, the public health model provides the best approach for reforming the system. The public health approach emphasizes collective action and cooperative efforts among diverse agencies and requires individuals, communities, organizations and leaders at all levels to collaborate in promoting mental health in children and youth.

Application of a public health model affords the opportunity to best use a community to establish a comprehensive children's mental health services system. Among the U.S. Surgeon General's major conclusions about children's mental health is the importance of assessing the mental health of children "within a developmental context that takes into account family, community, and cultural expectations about age-appropriate thoughts, emotions, and behaviors." (U.S. Surgeon General's Report, 2001). Mental health in childhood and adolescence is defined as "the achievement of expected developmental cognitive, social, and emotional milestones and by secure attachments, satisfying social relationships, and effective coping skills. Mentally healthy children and adolescents enjoy a positive quality of life; function well at home, in school, and in their communities; and are free of disabling symptoms of psychopathology." (Hoagwood et al., 1996)

Research over the past 30 years has elucidated a number of the risk factors that predispose children and adults to mental illness. A public health model emphasizes the necessity of incorporating health promotion and prevention practices into the development and delivery of services provided by the public mental health system. Prevention research has demonstrated that prevention can increase positive functioning and resilience, decrease the risk of developing mental illness, and facilitate recovery. Incorporating health promotion and prevention into the comprehensive children's mental health plan recognizes that mental health is essential to overall health and well-being.

Mental health promotion and prevention activities complement treatment and have as their goal the earliest possible detection of mental health problems across the

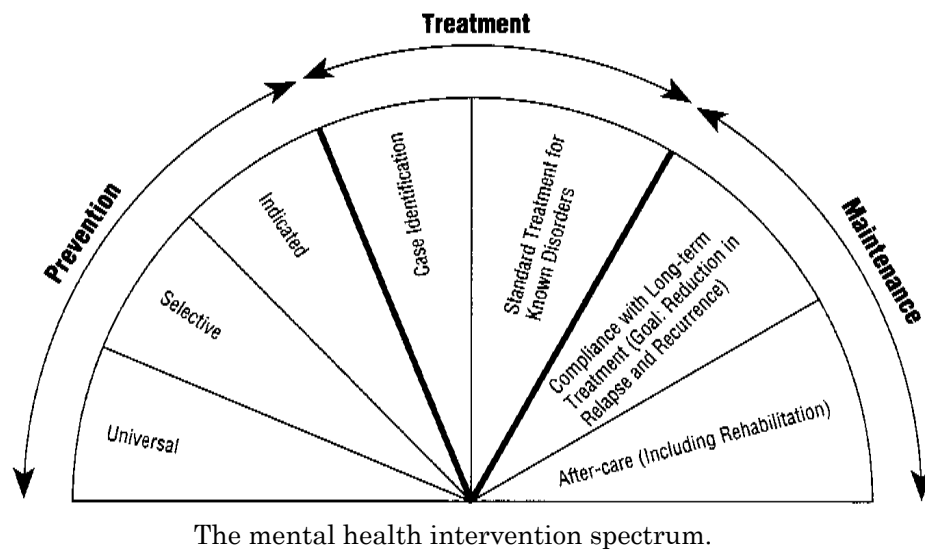
lifespan through routine comprehensive screening and assessment, and coordination of services among a broad range of disciplines.

Prevention research has demonstrated that prevention practices can reduce risk factors and enhance protective factors. Also, these interventions are a cost effective use of resources relative to more expensive, treatment-based approaches. Direct and indirect cost savings associated with prevention have been and can be substantiated.

The model used to organize the system components in the Plan follows the approach of the Institute of Medicine (IOM). In its 1994 publication, *Reducing Risks for Mental Disorders*, the IOM emphasized the need for adopting a preventive approach to mental health in order to reduce known risk factors, enhance protective factors, and reduce the incidences of severe mental illness and suicide. The authors described a spectrum of interventions for mental disabilities ranging from prevention through aftercare/recovery supports. This spectrum, see diagram below, emphasizes the importance of preventive intervention as a necessary component of addressing mental illness. This emphasis on prevention is a marked shift away from an emphasis on high intensity services for the severely emotionally disturbed. The authors and others (e.g., Suicide Prevention Plan, NASMHPD) argue that the individual, family, and societal impact of mental illness can be lessened through health promotion, universal preventive interventions, and preventive interventions with individuals and groups at high risk for developing a behavioral disorder or displaying early symptoms. In the behavioral health field, and in DMH, this approach is most realized in the areas of suicide prevention and prevention of substance use and abuse. Various studies have demonstrated the cost effectiveness of preventive interventions; namely, that benefits and savings from evidence-based preventive interventions in some cases heavily outweighs the cost, and in most circumstances produces more benefits and savings than doing nothing. Also, and most importantly, preventive interventions have the potential of reducing the number of children needing expensive, high intensity services as well as the number of children attempting and completing suicide.

The spectrum of preventive interventions has three major components: prevention (including early intervention); assessment, diagnosis, and treatment; and supports to prevent relapse and compliance with recovery and/or maintenance plans. The approach proposed by the IOM has also been espoused by the World Health Organization and was the subject of a State Medical Directors paper on prevention in the public mental health system. The development of an array of services across the spectrum will necessitate a shift in thinking about the role of the public mental health system. This “paradigm shift” will result in the public mental health system adopting principles from the broader public health field. Families, primary care providers, teachers and other school personnel, and communities will focus on

reducing the incidence of behavioral disorders and interrupting their development at the earliest onset of symptoms, in addition to providing necessary treatments and supports for those with a diagnosable disorder.



The Ideal Services Array Workgroup proposed adoption of a public health model consisting of three components:

- **Surveillance and assessment of mental health needs**, including risk factors, demographics, access in care, and rates of disease;
- **Policy development**, including financing, inter-agency collaboration, and policy initiatives; and
- **Assurance** that **prevention, treatment, and support services** are evidence-based and organized by developmental stages through a matrix of services, health promotion, quality, access to care, and evaluation and monitoring.

Role of partner agencies within the public health approach to mental health

Historically in Missouri as in other states, once a child entered any system, that system was responsible for meeting all the needs of that child. This led to each system developing some capacity for providing mental health services for the children they served, thereby creating a very fragmented mental health system. Viewing the mental health needs of children through a public health lens causes the focus of reform to shift from a “particular system” to that of a cross-system, non-categorical approach to improving the mental health outcomes for all children. This change from a medical to a public health approach necessitates that the

Department of Mental Health assumes the role of lead agency for the comprehensive mental health system as established in SB 1003. Working in partnership with the other child-serving agencies, the department will broaden its scope to: provide expertise to primary service delivery systems on responding to mental health service needs; provide oversight and leadership to ensure mental health services are effectively integrated into all systems; and work in collaboration with all state departments funding mental health services to set mental health policy and monitor the quality and effectiveness of mental health services across state departments. This type of “lead agency” role between state agencies already exists. The relationship between the Departments of Corrections and Mental Health concerning the substance abuse treatment needs of incarcerated individuals is one that fits the above description of the role of “lead agency.”

The public child serving agencies identified in SB1003 agree to work together with the Department of Mental Health in the design and implementation of the comprehensive system. Over the next five years, each agency will clarify its role in the comprehensive children’s mental health system within the context of each agency’s primary responsibility: teaching for schools; child safety for Children’s Division; community safety for the Juvenile Justice system; and promoting health for the Department of Health and Senior Services.

Characteristics of the Comprehensive System

To be effective, the comprehensive children’s mental health system encompasses three fundamental characteristics: Meaningful partnerships with families and youth; cultural competence; and a multi-disciplinary perspective. While each of these characteristics is woven throughout the plan, each is of such importance as to merit a more detailed discussion.

Partnerships with Families: Parents and care givers play a critical role in the lives of children; they are key to fostering mental health and early identification of problems; and they are central to the coordination of care for their children and the development of Individual Plans of Care. Family members also contribute integrity to policy group work by providing reality-based, culturally relevant information from a perspective that no one else has. Included among the Surgeon General’s major conclusions is that “families are essential partners in the delivery of mental health services to children.”

Meaningful family involvement doesn’t just happen. For family involvement, support, and development at all levels of the system to work, it must be thoughtfully organized with multiple strategies developed to engage the diversity of families potentially impacted by the system.

Cultural Competence: Cultural competence ensures that services are responsive to the cultural concerns of racial and ethnic minority groups, including their language, histories, traditions, beliefs, and values; cultural competence also ensures that services are responsive to the diverse needs of differing cultural traditions, differing socio-economic strata, and the differing social values of communities and regions. Cultural competence in mental health is an approach to delivering services that recognizes, incorporates, practices, and values cultural and social diversity. Our basic objective is to ensure quality services, including prevention, outreach, service location, engagement, assessment, and intervention, for culturally and socially diverse

Cross Agency Perspective: The transformation of Missouri's public mental health system from one providing intense services to severely emotionally disturbed children to one rooted in a public health model, which not only retains its service provision mission but also has the responsibility and expertise to promote mental and emotional health, prevent the onset of behavioral and emotional disorders (including substance use and suicide), and intervene early when risks are elevated and symptoms first occur, will require differing child-serving agencies to share a common framework for understanding the etiology of behavioral disorders in childhood. Also, it will require a common vision that conjoins physical health, academic and social development, and care and protection. Attaining a common framework requires a cross-agency, multi-disciplinary approach to children, their development, and their families.

As mentioned earlier, state agencies that have had responsibility for the care of children, from education to juvenile justice to foster care, have evolved their own, and agency-appropriate, means of responding to the mental health needs of children. Unfortunately, this has resulted in a fragmented system which marginalizes the role of families. This plan, which seeks a coordinated and comprehensive plan for children suffering from behavioral disorders and their families, recognizes the need for a cross-agency perspective. Carrying out the mandates of SB1003, and meeting the needs of Missouri's families and children, demands that child-serving agencies put children and their families first in policy and practice. The development of protocols for responding to the needs of families who have had to give up custody in order for their children to receive needed mental health services and the implementation of the Missouri SPIRIT school-based program indicate that a cross-agency perspective is achievable.

Achieving a cross-agency perspective and, therefore, the success of the implementation of this plan, will require: recognition of the Department of Mental Health as the agency of cognizance for mental, emotional, and behavioral disorders; an understanding that these disorders can occur in the community, schools, and

institutions; and an executive commitment to putting children and their families first. While this approach is emergent in the mental health field, it is long-practiced—that the public health agency is the agency of cognizance for childhood and communicable diseases is recognized by all state agencies; that the mental retardation and developmental disabilities agency is the agency of cognizance for those disorders is also recognized by all state agencies; and, recently, that the substance abuse prevention and treatment agency is the agency of cognizance for those disorders is increasingly recognized. The goal and challenge of this plan is simple: that policy recognizes that the mental health needs of children are recognized and responded to similarly across state child- and family-serving agencies.

This cross-agency, multi-disciplinary approach to the mental health of children is especially critical for **specialized populations of children** who have issues that cross many system boundaries and, due to the complexity of need, are at greatest risk for mental health problems. Children within special populations at greatest risk include children with autism; co-occurring mental health and substance abuse and/or developmental disabilities; sexually aggressive; physical health problems; family history of mental and addictive disorders; and issues related to trauma, caregiver separation or abuse and neglect. Youth aging out of children's services and in need of transition support and planning are another special population that requires a cross-system response. In addition to special populations, specific geographic issues stemming from isolated rural conditions must be responded to from a cross system perspective.

Linkages to other cross-system plans: The Comprehensive Children's Mental Health System provides the framework to link effectively with other plans that target the mental health needs of children and families. The State Suicide Prevention Plan, like the Comprehensive Children's Plan, emphasizes the public health approach and the collaboration of multiple agencies. The assessment of the risk and protective factors and the subsequent intervention strategies around suicide prevention are consistent with strategies of the comprehensive mental health plan. Mental disorders and substance abuse are risk factors that can increase the likelihood of suicide. The State Disaster Plan to address mental health needs of children following a disaster also must be linked to the Comprehensive Children's Plan. A disaster can impact the emotional, behavioral, and cognitive status of children. The strategies of the state's disaster plan for children include identifying high-risk children, screening and treatment. These strategies are consistent with the Comprehensive Children's Plan.

In 2003 the Department of Health and Senior Services, as the Title V agency for the state, received a 2-year, \$100,000 grant to develop a plan for a comprehensive early childhood system that builds on previous initiatives in the state and builds a

framework of collaboration between public and private entities. An Early Childhood Comprehensive System Coalition was formed with an interagency Steering Committee; and six focus areas were identified: Medical Home, Early Care and Education, Parent Education, Family Support, Disparate Outcomes and Mental Health and Social/Emotional Development.

The focus of Mental Health and Social/Emotional Development is on the education and support of primary caregivers (both parents and early education providers) in creating a safe and stimulating environment that supports healthy emotional development. Also, this group is focusing on providing information on identifying risk factors for emotional problems and/or developmental delays including the provision of screening tools and mechanisms available to families, care providers and pediatricians; and providing competent and developmentally appropriate mental health services and supports to the early childhood population as well as providing mental health services and supports to parents so they can meet the needs of their child. The basic premise is that information, services and supports should be available in the natural environments where young children live and learn. A documented goal for this system is to have a formal link to the Comprehensive Children's Mental Health Service System.

In the 2004 Legislative session a Coordinating Board for Early Childhood (a body corporate and politic) was developed that can take this plan forward in implementation.

RECOMMENDATIONS FOR A COMPREHENSIVE CHILDREN'S MENTAL HEALTH SYSTEM

The following service system descriptions and recommendations are organized according to the three public health model components: Assess mental health service needs; policy development; and the assurance of quality services and supports across the spectrum.

Assess mental health service needs statewide

Surveillance and assessment of mental health needs is critical to the development of the proposed system. Outside of data from the Missouri Student Survey (MSS) and studies of suicide, there is scant local or statewide data on the mental health needs of Missouri's children and families. The MSS provides the state with a picture of risk and protective factors associated with the onset of alcohol and other drug use, in addition to incidence and prevalence rates of substance use in Missouri's public school population, grades 6, 8, 10, and 12. Research indicates that there are clusters of risk factors that appear to be predictive of the development of behavioral disorders; yet, there are very few formal assessments of risk factors present in the population or subpopulations. In order to develop an appropriate array of services it is necessary to know the level of need for mental health services. Assisting communities with local needs assessments, gathering and comparing data from health assessments conducted by other state agencies, and implementing a statewide surveillance process are essential public mental health functions.

Recommendations for assessing mental health service needs:

- *The state partners will develop a "data warehouse" process to compile needed data across the multiple child serving agencies of the comprehensive system in an integrated and reliable manner including level of functioning, service needs, utilization and financial information across all of the involved agencies.*

A data warehouse is a process to compile data across multiple child serving agencies in a comprehensive, integrated, and reliable manner to permit quality decision making. The data include level of functioning, service needs, utilization and financial information across all of the involved agencies. Analysis of the data helps determine if the correct services are being provided, in the right duration, and in the most cost effective manner. DMH and its partners will seek grant or foundation funding to create this data warehouse. Concern will be taken to assure that the data collection procedures meet confidentiality and HIPPA statute and regulations. Activities will be coordinated with the Missouri Juvenile Justice Information System (MOJJIS) that is currently in use to collect data between the juvenile divisions of the circuit court and state agencies to ensure integration of all information within the system.

- *The Comprehensive Systems Management Team(CSMT) will develop a process to assist local areas to continually assess the factors contributing to mental health of children, to track emerging issues and to communicate findings to the CSMT.*

State and local assessment of mental health needs is essential to ensuring that services are appropriately located. To ensure the diverse geographic, cultural and full range of needs locally are assessed, the process developed must provide a mechanism for honoring local uniqueness while feeding into a broader policy development process.

The 2004 iteration of the Missouri Student Survey (MSS) provides an example of state and local assessment of mental health needs. The 2004 MSS was provided to the state's school districts as a web-based instrument with individual districts being able to access reports on risk and protective factors, incidence and prevalence of alcohol and other drug use, data on violent behaviors, and information about suicidal thoughts. In addition, the complete database is accessible by DMH and its evaluation and data analysis team in order to produce state-level and regional reports. These reports, which will be made publicly available, will assist the state and communities with planning the most appropriate array of services. Information about risks and protection and incidence and prevalence are essential for service planning and development. Under funding from the Substance Abuse and Mental Health Services Administration, DMH will develop a model for collecting, analyzing and reporting state-level needs-related data and for assisting communities with collecting, analyzing and reporting on local needs-related data.

Policy Development and System Administration

Policy development, including financing, inter-agency collaboration, and policy initiatives are essential public mental health functions. In order to attain the goals of system reform, it is necessary to develop policies that support the objectives and functions of the system. The development of policy proposals for the prevention, treatment, and aftercare of mental illness is a function of the public mental health agency. Public policies for addressing the mental health needs of Missouri's children and families are developed in collaboration with the other state agencies that have been providing mental health services for children, e.g., schools, the Children's Division, the Division of Alcohol and Drug Abuse, and others. Policy development must be directly related to an understanding of the extent of the problem and rooted in evidence-based principles. Public policy determines how the government will allocate its resources; therefore, inter-agency collaboration is essential to effective policy development and implementation. In an integrated system, implementation of policy requires a collaborative administrative structure that provides for both management and governance functions. Management and governance each have a distinct set of key functions that occur at very different levels within the state system.

Recommendations for policy development and system administration:

Policy: *Partner agencies jointly establish policy to support the following key system components:*

- *That the state interagency group convened as a result of SB1003 develop and implement a plan that ensures that children in need of mental health services receive them regardless of the system or environment in which that need is identified;*
- *That the Department of Mental Health consult with other state departments on the development of protocols for responding to the mental health needs of children;*
- *That funding follow the child, regardless of which system he or she starts in;*
- *That all child-caring systems are capable of identifying and assessing, if appropriate, the mental health needs of children (the “no wrong door”);*
- *That relinquishment of custody is not necessary solely to receive needed mental health services; and*
- *That the children’s mental health service system is family-driven, culturally competent and has a cross systems perspective.*

Policy Structure: *Create a formalized structure for policy & decision-making across departments at the Director level.*

This Governance structure will provide overarching leadership and vision for the system. As part of its leadership function, collaborative governance sets policies and decision-making in all areas of the Comprehensive Children’s Mental Health Service System including finance, family involvement, cultural competence, quality improvement, and workforce development.

Administration: *The Comprehensive System Management Team (defined in SB1003) functions as the management structure responsible for implementation of the system.*

The Comprehensive System Management Team (CSMT), as defined in SB1003, will provide a management function with operational oversight based on policy set by the Governance structure. The CSMT will operationalize the policies created by the governance body and function as linkage between state and local management structures

Stakeholder Input: *Create a Stakeholder Advisory Group to the Policy and CSMT level.*

The role of the **Stakeholder Advisory Group** after one year is to provide feedback regarding quality of services, barriers/success of the system, advocacy, public relations for the system, use of data to drive decision-making, and identification of emerging issues. The state interagency committee established in response to SB 1003 (hereafter referred to as the Governance Committee) will nominate two to three candidates that represent the local level covering the areas of prevention, early intervention, and complex treatment needs. The 30 members, representing all areas of the state and ethnic populations, will then be selected by the Governance Committee and appointed by the DMH Director to serve staggered three year terms with at least 51% of the membership representing families and youth.

The committee will elect a chair from among its membership, establish a set of operating guidelines or by-laws and a mechanism to review annually with the Governance Committee the composition of the membership and ensure broad representation consistent with the guidelines. The Stakeholder Advisory Committee will meet quarterly, at a minimum, with additional meetings as needed.

To ensure that members have the support they need for meaningful participation, all new members will receive an orientation to the Committee, the Plan and system development, and any reports and additional information needed to fully inform them. In addition family representatives will be provided opportunities to attend family focused conferences and training as part of their role on the Committee. Members will be reimbursed for the cost associated with participation including travel to and from meetings and meals.

Local Management:

- *Consider an area management structure that assures that the children's mental health services system serves the needs of communities and families and adapts to geographic and cultural differences.*

The Stakeholders Advisory Group strongly urged consideration of an area management structure in order to assure that the children's mental health services system serves the needs of communities and families and is able to adapt to geographic and cultural differences.

In a state as geographically large and diverse as Missouri, with an increasingly diverse population, moving some of the operational decision and planning functions to some kind of collaborative structure encompassing an area is a consideration. In order to assure both a broad platform for including the voice of families, stakeholders and the community as well as provide a reasonable management structure to coordinate and deliver services at the local level, it may be necessary to consider a larger regional

advisory mechanism tied to a smaller, local area management structure comprised of state and local agency staff and family representatives.

Family Driven

- *Increase family involvement at all levels of administrative structure*

If the comprehensive system is to function on behalf of children and families, then it is essential that families are included in the decision making and advisory structures. Parents of children currently or formerly in the children's mental health system and parents who have an interest in children's mental health, but do not have a child in the system, will be recruited to serve on the state and regional advisory groups. Family members will be recruited coalitions, advocacy groups, support groups and other venues. If the short and long term needs of children are to be effectively addressed, genuine family involvement in administrative structures is necessary.

Financing:

- *Ensure sufficient and flexible funding will be available to support an efficient system of prevention activities, services and supports.*
- *Establish an integrated funding mechanism to support required workforce enhancements.*
- *Create policy and fiscal mechanism to support family participation at all levels of system.*

In order for a comprehensive system to function properly, policy initiatives must include identification and allocation of necessary resources; essential resources that will support workforce development and services delivery. Though the Stakeholders Advisory Group did not conduct a formal resources assessment—one is recommended—anecdotal evidence suggests that many of the fiscal resources may be available for implementation of the plan; for example, preliminary results from an inventory of prevention resources being conducted by the Governor's Advisory Committee on Substance Abuse Prevention seem to indicate that there are various, but disparate, funding streams available.

To support the development of the proposed system, several fiscal strategies are proposed, including the restructuring of Title XIX (Medicaid), the redirection, when possible of funds from high cost institutional settings to community-based services, leveraging of state resources through the expanded access to federal Title IV-E reimbursement by DMH for children diverted from the Children's Division for voluntary placement to address mental health needs, and flexible use of existing state and federal block grant resources. Further support for the development of the proposed system, especially the prevention and early intervention components, will require assessing and leveraging, where possible, substance abuse and other prevention dollars from federal block grant and discretionary programs. Even if existing resources can be

leveraged for children's mental health services as described in this plan, new, additional dollars will be necessary to assure service adequacy and quality.

The Array of Services and Supports

Assurance that services are evidence-based, organized by developmental stages, reflect a matrix of services, and include mental health promotion is one function performed by the public mental health system. The public mental health system is also charged with assuring quality, access to care, and evaluating and monitoring service delivery and outcomes. Assuring that prevention, treatment, and support services are evidence-based will require mental health service providers to examine their practices and the competencies needed by the workforce. The Ideal Services Array workgroup initiated a review of evidence-based strategies, practices, and programs; completion of this review will be an early task of the Stakeholders Advisory Group. Two criteria of effectiveness are that services are age- and developmentally appropriate and culturally competent. Ongoing quality service reviews will help to ensure that programs and practices are evidence-based, practiced with fidelity to the model, appropriate for the child's developmental stage, and culturally competent. Ongoing monitoring and evaluation of services will help to ensure that desired outcomes, both system wide and for individual children, are being achieved and that care staffs are receiving the training and information necessary to support attainment of outcomes. In addition, monitoring and evaluation will help to ensure access to care and reduce disparities in the care received. Assurance activities, including workforce development, ensuring use of age and developmentally appropriate and culturally competent evidence-based practices implemented with fidelity, monitoring and evaluation, and ensuring access to quality care, are important functions of the public mental health agency.

Recommendations for array of services and supports:

Service Access

- *Any child can be screened for mental health needs at the first sign or request of a parent or child serving entity.*
- *Make available education, information and outreach to families on promoting mental health, risks and signs of mental illness, where to get help, information about their child's illness and availability of support.*

Families and advocates have long claimed that for the system to be responsive and effective, the system of services should adopt a "no wrong door" approach. The learning from the physical health area is that access to care does not require presenting one's self at a hospital door. Rather, accessing care is available from any door.

Population to be served

The Stakeholders Advisory Group recognizes that even if all potential sources of support for the reformed system are leveraged, there will not be sufficient resources

available. Therefore, some prioritization of system effort may be required in order to make most effective use of available resources.

Plan of Care

- *An Individualized Plan of Care and Care Coordination is available to all children, as needed.*
- *All children and families have access to the right level and mix of personally selected individuals, community and professional staff who join together to support the family and develop a cohesive, supportive IPC.*

The Individual Plan of Care (IPC) is a process for making decisions about which services and supports are provided to individual children and their families and flows out of the screening, assessment, and evaluation process. Not all children involved in the system will need a IPC. The needs of children involved in prevention activities and early intervention services and supports will be addressed by the program. The IPC process is an individualized, comprehensive, and coordinated planning process across child-serving systems. Missouri's individualized planning model(s) will ensure that the planning process gives the family and youth choice and decision making, is culturally relevant, and the services and supports identified match the level of need, and supports a community-based approach. An Individual Plan of Care is central to assuring each child and family served in the system has control over their services and that direct service planning and coordination occurs.

Key to assuring children receive the services and supports they need in a timely fashion is **care coordination**. To serve the broad range of children's needs, the system needs to incorporate a care coordination approach. The approach may vary based on level and complexity of need and may be provided by more than one system.

Bringing a team of individuals together to partner with a child and family to create an IPC builds on current Missouri resources as well as federal and state mandates by utilizing existing service planning entities within each system. Although current practice is not consistent across agencies and across the state, each system has access to or is required to develop an individualized planning team as a vehicle to address the unique needs of any child. These teams may already be involved with the child and reflect a group of individuals who know the child best in all areas of functioning and that are willing to meet on a regular basis to assist the child and family in identifying needs, supports, and services. Many children will never need a team but for children with severe and complex needs involved in more than one system a team provides an important cross-system perspective.

Service Array:

- *Make available in all areas of the state an array of services addressing prevention, treatment and ensuring a smooth transition to adult services when necessary.*

Evidence-based practices and quality assurance:

- *When possible, services and supports are based on effective and evidence-based programs and practices.*

Use of evidence-based practices is not uniform across the children's mental health services system. Implementation of evidence-based practices will require an assessment of risk factors and needs, training of the workforce, and identification of age- and developmentally appropriate practices and programs. Research over the past 20 years has concluded that there are practices and programs that are proven to be effective in addressing the mental health needs of children and their families; and many of these practices and programs are, additionally, cost-effective (see Washington State study). The bulk of the research has been in the specialties of substance abuse and delinquency prevention and they have clearly demonstrated that effective programs and practices, administered with fidelity, are likely to reduce substance use and delinquency. In fact, Mary Ann Pentz, Ph.D, has stated that declines in child and adolescent use of marijuana and other illicit drugs and, to a lesser extent, alcohol can be traced to the adoption of evidence-based prevention curricula in schools and by communities (Pentz, 2004). Preventive intervention programs such as Multi-systemic Therapy are proven to interrupt progression to adult criminality and addiction and alcoholism and to result in increased socially appropriate behavior and strengthened families; Family Strengthening programs reduce inter-generational transmission of behavioral disorders and enhance chances of social success. Locally, early results from Missouri SPIRIT seem to indicate that evidence-based programs implemented with fidelity effectively address risk factors for development of behavioral disorders; absenteeism rates are lowered, school disciplinary incidences are lowered, and alcohol and other drug use among high school students is markedly reduced. Evidence-based programs can reduce, over time, the cost of untreated or ill-treated behavioral disorders. Yet, it is necessary for even the most highly effective program or practice-set to be implemented with fidelity.

Quality monitoring and assessment is a necessary component of an effective system. Routine and ongoing quality monitoring and assessment helps to assure that the care needs of children are being met in the most effective manner; and that family involvement, a crucial element of effective care, is maximized. Quality Service Reviews, which are being implemented in Missouri System of Care sites, are an example of a methodology to ensure that the services provided are effective and appropriate; this quality assurance methodology will be extended throughout the state as resources allow.

Workforce Development:

- *Consistent training on emotional risk factors for all partner agency staff, local school and court personnel and physical health practitioners.*
- *Competency-based training in identified evidence-based practices*
- *Systematic orientation to the comprehensive system across all systems with a focus creating strengths-based partnerships with families.*

Implementation of the Comprehensive Children's Mental Health Services System will require a commitment from all partners to workforce development and the overall education of stakeholders regarding the mental health needs of children. The education must be inclusive of all stakeholders and include a description of the structure and process of the system. There is also a need for a systematic approach to staff orientation and skill building to ensure competence in identification, assessment, and treatment, including clinical expertise, of mental health needs. Finally, a comprehensive funding strategy to support ongoing training activities across all systems is a critical component.

While the training requirements are massive and critical to the overall success of the Plan, training is not the only issue relevant to the development of a competent workforce. The Current Mental Health Services Workgroup identified additional workforce issues including staff turnover and retention, the need for competitive pay ranges for qualified staff and the severe shortage of qualified mental health staff in most of Missouri's rural areas. The Missouri Foundation for Health reported that three-fourths of Missouri's counties are considered mental health professional shortage areas (Missouri Foundation for Health, 2002). Lack of qualified staff creates service access difficulties related to all types of mental health services.

Evaluation and Monitoring for Quality Service:

- *Incorporate a quality improvement process including mechanisms for shared data collection and the Quality Service Review process to assure that data is used to monitor both system performance and child and family outcomes and monitoring results are used to improve the system.*
- *Develop and conduct an evaluation of implementing evidence-based prevention and early intervention programs, including measuring fidelity.*
- *Assure meaningful roles for youth and family members in the monitoring and evaluation.*

The Comprehensive Children's Mental Health Initiative will provide the full array of mental health services, from prevention to inpatient care, involving multiple state as well as private agencies and providers. Collecting and analyzing data will be critical to the success of the system. We know that the various components of the existing system do not "talk" with one another very well when it comes to data and information. A top priority must be the establishment of a useable data system across all the agencies involved in the Comprehensive Children's Mental Health Initiative.

The purposes of the data collection system are: to maximize the effectiveness of services and assist with decision making; and to evaluate the service system and its components to ensure accountability, efficiency and progress in achieving successful outcomes for children and their families.

There are both data collection and evaluation processes being used for specific components of the existing system. These processes include the **Missouri Juvenile**

Justice Information System (MOJJIS) and the **Quality Service Review**. MOJJIS is currently in use to collect data between the juvenile divisions of the circuit court and state agencies. The QSR process is being used to measure the quality and improvement of system in local system of care sites. Expanding and adjusting these processes along with the development of the proposed **Data Warehouse** and then applying them across the components of the system as it develops will provide the needed data collection, analysis, and accountability measurement. In addition, an evaluation of the implementation of evidence-based programs at selected sites will be undertaken.

Quality Service Review (QSR), which was designed by Dr. Ivor Groves of Human Systems and Outcomes, Inc., a nationally recognized expert on measuring system effectiveness, measures the quality of interactions between frontline practitioners and children and their families and the effectiveness of the services and supports provided. Under the QSR concept, each child served is a unique “test” of the service system. It is based on the logic that each child and family reviewed through the QSR becomes a unique and valid descriptor in assessing the system’s performance. The QSR highlights the strengths of the system, as well as the areas that need improvement.

The technique has a strong background in Missouri as it has been used extensively by the Department of Social Services (DSS) for Practice Development Review. It was also used with the Children’s System of Care Project established by the State System of Care Team, now known as the Comprehensive Service Management Team. The agencies and child advocates realized that in order to evaluate the effectiveness of the System of Care project and its components, the measurement process had to move beyond just reporting data about families served, to a measurement tool devised to track progress, measure quality, and make adjustments. The project builds on the previous use of the technique by DSS.

Ongoing Public Input

Reform of the children’s mental health system in Missouri is an ongoing process. The development and implementation of the plan for a comprehensive system is based on uniting the multiple state agencies and broad array of stakeholders in a commitment to better serve children and their families. Input has been a key component of the reform effort up to this point. Input from all stakeholders will be perhaps the most critical piece to assure continued success of this effort.

The stakeholder advisory group will continue to be the sounding board for ideas and the compass for direction as the state move the plan forward. Beyond this group, however, public input will be an ongoing part of the process.

Strategies will be implemented to obtain input from child mental health providers, the juvenile justice community, judges, educators, legislators, child and family advocates, and parents. A tremendous amount of input has been received to date from these stakeholder groups, and the process will continue to focus on these key interests.

Strategies include: holding public meetings throughout the state; participating in local, regional and statewide meetings, conferences and trainings; and soliciting comments on the plan through the worldwide web.

This input must not only come from the broadest array of stakeholders possible, it must also come from all levels of the system. - From individual parents, and families, and local providers and judges, to regional and statewide agencies, advocates and policymakers.

Summary of Recommendations and Goals

Developing a unified, comprehensive children's mental health system that provides a full array of services across developmental stages will require significant changes in financing; new program development; the implementation of new administrative structures and collaborative arrangements; and major workforce development efforts. To reflect the complexities involved in a change of this magnitude, the Plan reflects a five year transition plan for the creation of the necessary service capacity, infrastructure and management mechanisms. Effective management of a complex change process requires careful attention to sequencing and a mechanism for making mid-course corrections. The process will necessarily be incremental, as resources are shifted and capacity develops. The following is a summary of the recommendations along with a guide to both short and long term implementation goals planned for the next five years.

Recommendations & Goals of the Comprehensive Children's Mental Health Services System

| Recommendation | Short-Term Goals | Long-Term Goals |
|---|--|---|
| Assess Mental Health Needs | | |
| Develop a “data warehouse” process to compile needed data across the multiple child serving agencies of the comprehensive system in an integrated and reliable manner including level of functioning, service needs, utilization and financial information across all of the involved agencies. | <ul style="list-style-type: none"> Explore grant or private foundation funding to develop data warehouse. | <ul style="list-style-type: none"> Develop data warehouse process |
| Develop a process to assist local areas to continually assess the factors contributing to mental health of children, to track emerging issues and to communicate findings to the CSMT | <ul style="list-style-type: none"> Review current and proposed statewide and local assessments of behavioral health needs as the basis for conducting assessments of mental health needs. | <ul style="list-style-type: none"> Phase in statewide community assessment process to determine risk and protective factors, incidence and prevalence; risk levels among populations; available resources; and community readiness to act. |
| Policy and Administration | | |
| Jointly establish policy to support key system components | <ul style="list-style-type: none"> Create a formalized structure for policy & decision-making across departments at the cabinet level. | |
| The Comprehensive System Management Team (defined in SB1003) to function as the management structure responsible for implementation of the comprehensive system. Provides coordination and | <ul style="list-style-type: none"> Finalize CSMT structure, protocols, and membership Provide orientation to all members regarding comprehensive system, | <ul style="list-style-type: none"> Include team membership responsibilities into job descriptions for CSMT |

| Recommendation | Short-Term Goals | Long-Term Goals |
|---|---|---|
| oversight to local system. | role and function of respective groups. <ul style="list-style-type: none"> • Develop a process and structure for communication regarding system implementation and reporting mechanisms | representatives. |
| Create a Stakeholder Advisory Group to the Policy and Administrative interagency structures. | <ul style="list-style-type: none"> • Develop charge to Stakeholder Advisory Group • Identify & orient membership • Create workgroups, as identified by group to include <ul style="list-style-type: none"> ○ Public Education ○ System Development Monitoring ○ Enhancing Parent Involvement | <ul style="list-style-type: none"> • Develop ongoing mechanism for communication with system structures. |
| Consideration of an area management structure to assure the children’s mental health system serves the needs of communities and families and is adaptable to geographic and cultural differences. | <ul style="list-style-type: none"> • Explore composition and structure of local area interagency/stakeholder teams • Increase family and youth membership on existing local/area interagency teams representing a broad perspective of needs and systems. • Establish reimbursements/supports to facilitate family involvement. • Create mechanism to support parents working in each child serving agency to function as resource guides to assist | <ul style="list-style-type: none"> • Develop evaluation data and community needs assessments to inform resource allocation across systems. • Ensure local mechanisms for a clinical quality/utilization review process, barrier identification and technical support is available to individual |

| Recommendation | Short-Term Goals | Long-Term Goals |
|---|---|--|
| | families in accessing information about the systems and to serve as a feedback mechanism for the Stakeholder Advisory Group. | child and family teams. <ul style="list-style-type: none"> • Identify how the system will interface with service providers. • Include team role and responsibilities in job descriptions, performance appraisals across all systems. |
| Increase family participation at all levels of administrative structure. | <ul style="list-style-type: none"> • Actively increase family involvement at all levels, including families representing various systems. • Expand family supports to facilitate involvement including transportation, childcare, and any special needs to participate (interpretation). | <ul style="list-style-type: none"> • Provide capacity-building support that gives families the information, skills, and confidence to partner, including training, peer and non peer mentoring. |
| Financing: <ul style="list-style-type: none"> • Ensure sufficient & flexible funding will be available to support an efficient system of activities, services and supports across the service spectrum. • Establish an integrated funding mechanism to support required workforce enhancements • Create a policy and fiscal mechanism to support family participation at all levels. | <ul style="list-style-type: none"> • Conduct a formal assessment of resources currently available for children’s mental health services across federal and state agencies. • Submit FY05 budget request to support priority services. • Implement the voluntary placement option under Title IVE of the Social Security Act. • Expand home and community based mental health services available | <ul style="list-style-type: none"> • Create incentives to expedite eligibility and support home and community-based services, when appropriate • Develop strategies for blending or braiding funding to assure non categorical service capacity. |

| Recommendation | Short-Term Goals | Long-Term Goals |
|--|---|---|
| | <p>through changes to the Medicaid Community Psychiatric Services Rehab Option for children.</p> <ul style="list-style-type: none"> • Seek federal approval for a home and community based waiver program [1915(c)] for children with SED, including children returning to the community from placement under SB266 | <ul style="list-style-type: none"> • Explore options for a research and demonstration waiver to blend federal funding streams (1115C) to support a comprehensive system. • Identify a payment structure/methodology for the system. |
| The Array of Services and Supports | | |
| <p>Service Access:</p> <ul style="list-style-type: none"> • Any child can be screened for mental health needs at the first sign or request of a parent or child serving entity. • Make available education information and outreach to families on promoting mental health, risks and signs of mental illness, where to get help, information about their child's illness and availability of support. | <ul style="list-style-type: none"> • Develop a plan and establish responsibility for educating professionals and others about mental illness and to detect early warning signs. • Pilot 3-4 indicators in each age bracket on emotional/mental health risk factors within current Medicaid health screen for children (EPSDT) • Develop materials to educate families and disseminate. | <ul style="list-style-type: none"> • Based on pilot, explore development of a partial mental health screen under Medicaid EPSDT • Material will be disseminated across the state to professionals, schools, and medical staff. • A public education campaign will be developed for media and community use. • All new parents will receive this information at birth or |

| Recommendation | Short-Term Goals | Long-Term Goals |
|---|--|---|
| | | following adoption. |
| <p>Plan of Care:</p> <ul style="list-style-type: none"> • An Individualized Plan of Care is available to all children, as needed • Care Coordination is available to all children, as needed. | <ul style="list-style-type: none"> • Create a workgroup to conduct assessment of the care plans currently used by the various agencies and staff and identify essential requirements. • Test a nationally recognized IPC model in the two federally funded system of care sites and conduct a fidelity study. • Based on assessment of current practice and findings from test sites, the CSMT will explore feasibility of adopting a comprehensive care plan with a universal format. • Develop mechanisms to ensure safeguards for family voice when they don't agree with their care coordinator, team, or provider agency. | <ul style="list-style-type: none"> • Field test the universal care plan format • Develop a curriculum to train staff in ICP development • Conduct a review to determine the feasibility of utilizing the IPC as the method for authorizing funding at the individual child level and how funding would flow in support of the IPC. |

| Recommendation | Short-Term Goals | Long-Term Goals |
|---|--|--|
| | <ul style="list-style-type: none"> Care coordination mechanisms to be explored as part of ICP workgroup activities. | |
| <p>All children and families have access to the right level and mix of personally chosen representatives, community and professional staff who join together to support the family and develop a cohesive, supportive service plan.</p> | <ul style="list-style-type: none"> Create an interagency task force to assess status of current practice, identify commonality of tools and practice across systems and identify best practice. Develop tool kit and training curriculum to ensure consistency of practice statewide Pilot in federally funded system of care sites | <ul style="list-style-type: none"> Train across all systems statewide Ensure fidelity through incorporation into Quality Service Review Support practice by incorporating practice expectations into job descriptions, performance appraisals, and supervisory functions. |
| <p>Service Array:</p> <ul style="list-style-type: none"> The system will have available in all areas of the state an array of services addressing prevention, treatment and ensuring a smooth transition to adult services when necessary. Evidence-based practices established whenever possible based on effective and evidence-based programs and practices. | <ul style="list-style-type: none"> Hold a state level summit on school-based mental health services. DESE and DMH to identify EBP within school-based mental health and highlight successful programs Conduct national scan for appropriate evidence-based practices Expand SPIRIT activities | <ul style="list-style-type: none"> Expansion of service capacity based on capacity study. Select and implement evidence-based practices Monitor and evaluate programs through QSR |
| <p>Workforce Development</p> <ul style="list-style-type: none"> Consistent training for all partner agency staff, school personnel, and physicians on emotional risk factors. Ensure competency-based training statewide in | <ul style="list-style-type: none"> Develop a workgroup to assess training needs, available resources, identify workforce issues and develop a comprehensive training plan. Promote a strength-based, family | <ul style="list-style-type: none"> Develop cross system funding mechanism to support orientation and identified training on system. |

| Recommendation | Short-Term Goals | Long-Term Goals |
|--|--|--|
| <p>evidence based practices.</p> <ul style="list-style-type: none"> • All training includes a family strengths-based and cultural competency approach. | <p>partnership model in all service development and staff training across all agencies.</p> | <ul style="list-style-type: none"> • Establish mechanism for ongoing workforce development to ensure evidence-based practice across front-line staff. |
| <p>Evaluation and Monitoring for Quality Service</p> <ul style="list-style-type: none"> • Incorporate a quality improvement process including mechanisms for shared data collection and quality services review to assure that data is used to monitor both system performance and child and family outcomes and monitoring results are used to improve the system • Develop and conduct an evaluation of implementing evidence-based prevention and early intervention programs, including measuring fidelity. • Youth and family members will have meaningful roles in the monitoring and evaluation. | <ul style="list-style-type: none"> • Seek grant or foundation funding to support development of a Data Warehouse • Complete QSR pilot in local system of care sites and develop report. • Develop mechanisms to ensure random selection of child & families for QSR process and safeguards protecting families from reprisal as a result of their participation in an evaluation of their child's services. | <p>Phase in QSR process throughout the system.</p> |

STATUS OF REFORM

Background

For 15 years, the Missouri Department of Mental Health (DMH), advocates, family advocates, and providers have worked together with other state child-serving agencies to improve outcomes for children with mental health needs and their families. In 1989 Missouri received a five-year grant from the National Institute of Mental Health and initiated the Child and Adolescent Service System Project (CASSP); and local interagency teams were developed in key sites. In 1992-93, in response to House Bill 503, DMH piloted the 503 Project, an interagency System of Care (SOC) demonstration for children and youth with severe emotional disturbances (SED), in St. Louis County. In 1998, the Interdepartmental Initiative for Children with Severe Needs and Their Families began. This ambitious effort among the state's child-serving agencies, while not realizing all of its goals, did further the development of community-based services and provider networks. The Missouri System of Care (SOC) initiative was launched in 2002 with the creation of a state level SOC interagency team, which included families, advocates and representatives from all state child-serving agencies. In 2002 local projects were implemented in six counties across the state.

In addition to the above efforts, the state also implemented Missouri's Caring Communities initiative, which linked the services of schools, neighborhoods, and public agencies in 21 communities and across eight (8) State agencies. Both Caring Communities and SOC have been primary vehicles through which various public service agencies and families have come together to develop public policy regarding children, youth and families.

Senate Bill 1003 (SB 1003) is the culmination of these early efforts in addition to being a consolidated response to previous legislation addressing some parents' being required to relinquish custody in order to obtain necessary mental health services. The recommendations in the Comprehensive Children's Mental Health Plan build on existing resources, draw from research on preventing and treating mental disorders, and incorporate past experiences as the starting point for creating a truly comprehensive, responsive, and evidence-based system of mental health services for Missouri's children and their families.

Current Status of System Change

The challenge during any system development is to launch and sustain a necessary three-part strategy that : 1) addresses the immediate press of relinquishment of custody created by the unmet needs in the current system; 2) broadens and expands the collaborative state and community resource pool; and 3) creates a system improvement process to ensure that the most effective resources are available with the most efficient pathways to access these resources. DMH and its partners have already made great strides in addressing issues identified in the legislation as

Reforming Children's Mental Health Services in Missouri
A plan submitted to the General Assembly per S.B. 1003.

needing an immediate response. Work has also begun to identify ways to enhance and broaden needed resources and to create mechanisms for system improvement. Other relevant initiatives have also been consolidated under the comprehensive system planning process to streamline efforts and enhance the final system. The following is a status report of efforts to date.

1. Immediate Response Activities

Relinquishing Custody

As noted previously in this report, the inability of the current system to meet the mental health needs of children and their families can sometimes cause families to relinquish custody of their child to the state for the sole purpose of accessing mental health care. This usually involves children with the most severe needs. Legislation passed in each of the past three legislative sessions – Senate Bill 923, Senate Bill 266, and Senate Bill 1003 – has taken steps to address this horrible situation for families.

Diversion Protocols

One step has been the development of a protocol to divert families from the facing the situation of considering relinquishing custody when their only need is mental health services. The protocol is specific steps that child serving agencies must follow in those cases involving parents who are considering voluntarily relinquishing custody of their child for the sole purpose of accessing mental health care. The protocol has been implemented in the 12th Judicial Circuit, which includes Audrain, Montgomery, and Warren counties, and the 21st Judicial Circuit which includes St. Louis County. All judicial circuits have been trained in the use of the protocol, making implementation possible throughout the state.

The protocol is predicated on the belief that no parent should voluntarily have to relinquish custody of their child to access mental health services, if clinically appropriate services and supports, either within or outside the home setting, can be provided to the youth and family. So far, in the communities using this protocol, 20 children have been diverted from state custody, and 75 percent of those children were supported in their community while remaining with their families.

Returning Children to Custody of their Parents

Another step has been the identification of children already in state custody solely for mental health services, and returning custody of those children to their families. Senate Bill 266 called for the identification of those children and Senate Bill 1003 established a framework to return those children to the custody of their parents, when appropriate.

The Department of Mental Health and Department of Social Services hired Alicia Smith & Associates to conduct the evaluation called for by Senate Bill 266. The report identified 296 children ages 3 – 17 that likely entered foster care during a

one-year timeframe between January 1, 2002, and December 31, 2002, solely to access mental health services; the report also estimated that there were approximately 300 children already in the foster care system during that period who appeared to meet the criteria. The criteria for identifying these youth were:

1. The circumstances for removal were identified as: child's behavior problem; child's disability; child's alcohol abuse; child's drug abuse; abandonment or relinquishment; and
2. The child was placed in an institutional setting within 90 days of being placed in state custody for any of the above reasons except abandonment.
3. When the circumstance was abandonment, the child was placed in an institutional setting on the date they were placed in state custody.)

Identified Children with any of the following were then screened out of the final report:

1. Those with a substantiated report of child abuse or neglect within the year prior to state custody.
2. Those with a moderate or severe mental retardation disability.
3. Those who did not access mental health services within six months of being placed in state custody.

In 2004, the Children's Division (CD) initiated a case review process using the proxy method developed by Smith. This review identified approximately 550 children who met the criteria. The CD, upon further review of these 550 children, identified 112 in state custody who possibly meet SB 1003 criteria of as having been placed for need of mental health care only. Children's Division staff is in the process of convening Family Support Teams for the children identified to determine future custody status. The CD is also in the process of conducting a more detailed review of the remaining 438 children in order to assure that all efforts to identify and return to the custody of families are implemented. As families come forward and self identify as having given up custody to obtain mental health services for their child, these children will also be reviewed through the Family Support Team process. A separate report has been developed jointly by the Departments of Mental Health and Social Services detailing efforts and status of children identified through procedures established under SB 266 and SB1003.

2. Activities to Enhance and Broaden Resources

Workforce Development and Training

A critical component of a successful child mental health system is the cooperation of the juvenile justice and mental health system. A concerted effort to further this cooperation is underway. Training has been conducted with the juvenile justice system on the implementation of SB 1003 and the development of a comprehensive children's mental health services system. At the Missouri Juvenile Justice Association conference in October, 2004, training was provided on the Plan for the

children's mental health system, as well as on the issues of custody diversion, custody transfer and Quality Service Review.

In addition a specific effort was made to improve collaboration between the juvenile justice and mental health systems. The first of four scheduled regional trainings were held with juvenile justice and mental health providers attending as local, interagency teams. At this training, the teams heard a national and state perspective on mental health and juvenile justice issues. Teams also met for facilitated discussion of the roles and responsibilities of the members of the team. The teams were encouraged to develop local solutions and identify what needs to be done at the state level to enhance cooperation between the juvenile justice and mental health systems.

Also critical is the working relationship between the local school systems and mental health systems. The Missouri school counselors, at their annual conference in November, 2004, identified some of the issues that need to be addressed in order to enhance collaboration with mental health service providers. These issues included: language barriers between mental health providers and school personnel; the need for funding for programs and services in schools; lack of local access to mental health services; accountability for mental health providers; the need to be included as part of a team with mental health providers; and the lack of mental health professionals and services in some areas of the state. A plan to address these and other issues with local schools is being developed and will be incorporated into the Comprehensive Children's Mental Health Services System Plan.

A review of the health professional shortage areas in Missouri for both mental health professionals and psychiatrists indicates a critical need for these services. Families and providers have consistently reported lack of local access to child psychiatrists and psychologists as fundamental problems in accessing services. To address this problem, the Department of Mental Health and Department of Health and Senior Services are working to encourage mental health care professionals with child expertise to provide services in shortage areas. Some of the efforts include a waiver program from the U.S. Department of State that waives the requirement for students in the mental health professions to return to their native country in exchange for three years of service in a health professional shortage area; and a program which repays outstanding educational loans in exchange for providing services in areas of need in Missouri. Participants must accept Medicaid consumers. The Department of Elementary and Secondary Education (DESE) and Department of Higher Education (DHE) are engaged in mental health training activities. DESE's Division of Special Education has implemented a system of personnel development that is coordinated with each school district's Professional Development Plan. Under this initiative, local schools assess and identify their needs regarding: (1) the number of qualified personnel available to serve all students with disabilities; (2) the appropriate in service training that staff need; (3) required training for paraprofessionals; and (4) dissemination of relevant research, instructional strategies, and adoption of effective practices.

For the past four years, the Department of Mental Health and the Curators of the University of Missouri – Columbia have had a contract for the Center of the Advancement of Mental Health Practice in Schools. The Center is intended to:

- Assure that University trained teachers and school administrators are well grounded in the principles of and effective approaches to: (1) mental health promotion; (2) early identification and intervention in public mental health problems; and (3) collaboration with the public mental health system in serving children and youth with serious emotional disorders and their families.
- Prepare school based mental health practitioners trained to offer families, children and youth mental health services and supports within the school environment; and
- Promote the development of best practices in public mental health promotion and prevention, early identification and intervention, and treatment services and supports in the school setting.

The Center has received recognition for its efforts in promoting awareness of school-based mental health issues, including: national recognition from the National Center for School Mental Health Assistance for one of its mental health modules and one of its online courses. There are 21 graduate students enrolled in Center programs.

Financing

Senate Bill 266 passed in 2003 mandated that the state evaluate the number of children who had likely been placed in the custody of the state solely to gain access to mental health services, and to make recommendations for financing those services. The Department of Mental Health hired Alicia Smith & Associates to conduct the evaluation, which was noted above under “relinquishing custody.”

The Alicia Smith report estimated the cost to treat these children at approximately \$3,600 per child per month, or about \$43,000 per year in state and federal funds. The report recommended two options for the state to pursue to address both the children identified in the report, and the development and implementation of the comprehensive children’s mental health service system. The recommendations are: Voluntary Placement option under title IV-E of the Social Security Act; and Section 1915 (c) home and community based waiver under the Medicaid Rehab Option.

Voluntary Placement under Title IV-E

Voluntary placement allows a family to relinquish physical custody but retain legal custody of their children. These children become eligible for mental health services reimbursed by Medicaid and residential services funded with Title IV-E funds. The voluntary placement is for 180 days and is meant to be a respite for parents. This option does not solve the problem of long-term residential care, but the state is exploring this as an option for a small subset of children. The Voluntary Placement

Option will operate in conjunction with the Diversion Protocol mentioned previously. The Voluntary Placement will be available statewide as of January, 2005.

1915 (c) Home and Community Based Waiver

The 1915 (c) waiver allows the state to receive federal matching funds to offer an array of community based services to children who would otherwise receive institutional placement. Initially, the waiver would cover those children identified by Senate Bill 266 who would be returned to the custody of their families. It is possible to expand this program to additional children as state funds become available. The waiver could also be used to help finance the comprehensive children's mental health service system.

The state has set up a financing workgroup to plan for this waiver. The Department of Mental Health and Children's Division are working to apply for the waiver in 2005. Depending on the response from the federal government, implementation could begin in mid to late 2005.

Services

Prevention

The promotion of mental health and the prevention of mental illness is a goal of the comprehensive children's mental health system. Promoting positive mental health and preventing the onset and progression of behavioral disorders can reduce deaths and injuries. The Missouri School-Based Initiative, Missouri SPIRIT, is a pilot program demonstrating the efficacy and effectiveness of implementing evidence-based prevention programs in schools. Information from the first two years of the program strongly suggests that there are not only reductions in alcohol and other drug use, but also improvements in school climate—including, reductions in violent behavior among high school students and reduced numbers of children with 10 or more absences per year. SPIRIT is demonstrating that evidence-based programs, implemented with some fidelity, can, not only reduce behavioral disorders, but also improve school environment. The DMH proposed budget for FY2006 includes a request for funds to expand the SPIRIT project to additional schools.

The DMH has also received a grant to develop and implement a "strategic prevention framework." The purpose of the grant is to develop and implement a statewide infrastructure for substance abuse prevention, mental health promotion, and mental illness prevention. The strategic prevention framework consists of the following five steps: conduct needs assessments; build state and local capacity; develop a comprehensive strategic plan; implement evidence-based prevention policies, programs and practices; and monitor and evaluate program effectiveness, sustaining what has worked well.

Early Identification and Intervention

A primary goal of the comprehensive children's mental health system is to ensure that children who need mental health services and supports receive them earlier, rather than later. Early identification and intervention will allow these children to be helped in the community and before the need for institutional services. Early treatment is only possible when children in need are identified early in the progression of their illness. The comprehensive system will emphasize early identification through intensive campaigns to teach physicians and providers, school personnel and parents how to identify a child in need of mental health services and how to obtain appropriate services.

The Department of Health and Senior Services received a two-year planning grant to strengthen collaboration and promote effective utilization of resources through development of an Early Childhood Comprehensive System. The Department of Mental Health is on the Interagency Steering Committee. The Early Childhood Comprehensive System Planning Coalition is made up of representatives from the Children's Services Commission Subcommittee on Early Childhood, as well as families and other groups with strong early childhood interests. Additionally, subcommittees have been formed to address the five mandated focus areas: Access to Medical Homes; Mental Health and Social-Emotional Development; Early Care and Education/ Child Care Services; Parent Education Services and Family Support Services; and Reduction in Minority Health Disparities.

HB1453 established a Coordinating Board for Early Childhood with representation from the departments of health and senior services, mental health, social services and elementary and secondary education; governor's office; the judiciary; the Family and Community Trust Board; Head Start; and nine members appointed by the governor representing groups such as business, philanthropy, civic groups, faith-based organizations, parent groups, advocacy group, early childhood providers and other stakeholders. The Coordinating Board will develop a comprehensive long-range plan for a cohesive early childhood system, promote and improve the development of children from birth to age five, identify legislative recommendations to improve services for this population, promote coordination of existing services and programs, promote research-based approaches to services and ongoing program evaluation, and identify service gaps. A Coordinating Board for Early Childhood Fund was also established which can accept private and public moneys to carry out its duties.

School-based services

Efforts are underway between the education community and mental health to explore how education and mental health can work together to better utilize resources and provide services for school-age children. The Department of Elementary and Secondary Education, the Children's Division, Medicaid, Missouri School Board Association and Department of Mental Health are reviewing the current practices in Missouri related to school-based mental health services. The review includes an analysis of the mental health services currently provided in the

schools, the payer of these services (e.g. Medicaid, IDEA), identifying the gaps in mental health services in the schools, exploring how these services can be funded through Medicaid, and finally establishing standards of care for the services. As a means of beginning this work, focus groups were held this fall with local school personnel to provide their perspective on mental health needs of children in school. In a jointly DMH and DESE sponsored focus group held with the support of the Missouri School Board Association, participants recommended that treatment and services for children with mental health issues needs to be in the context of the school environment. A presentation on SB1003 was made to School Counselors who identified barriers that will need to be addressed as school-based services are developed.

Juvenile Justice

The Missouri Alliance for Youth is a partnership between the Department of Mental Health and juvenile justice system. The partnership is committed to improving services for youth with mental health needs involved in the juvenile justice system. For example The Alliance supported the MO MAYSI Project which screened youth in detention, Division of Youth Services and referred from the community to the juvenile office for mental health needs and issues. Results were reported separately and as a comparison across these 3 groups. Thirty-six percent of the youth screened has a history of mental health services. Approximately 74% of the youth screened positive on at least one scale. Full reports on this data are available through the DMH. In FY004 the Alliance Steering Committee provided support for a budget item for the DMH to support partnerships between community mental health centers and juvenile offices to better serve youth at risk of or currently in the juvenile justice system. The Alliance also currently supports implementation of a Challenge Grant through the Department of Public Safety with a focus on training for mental health and juvenile justice professionals to work more collaboratively.

3. System Improvement Process Activities

Federal Grants

The Department of Mental Health in partnership with other child serving entities has helped develop local interagency teams to oversee coordinated community-based services for children with complex mental health needs requiring services from more than one system and their families. Currently local teams are working in Adair County; St. Louis City and St. Louis County; Jackson County; St. Charles County; St. Francois County; and Butler and Ripley counties. Federal grants have helped to support this effort by providing funding for an integrated, inter-agency, community-based “System of Care” in three areas of the state. The Partnership with Families in St. Charles County just completed a six year federally funded initiative that helped to create an integrated system of care. In 2001, the state was awarded a six-year federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to support system of care development in the southwest counties of Greene, Christian, Taney, Stone, Barry and Lawrence. Local project development for this system of care is managed through partnerships with two

Department of Mental Health Administrative Agents – Burrell Behavioral Health and the Clark Center. The DMH also received SAMHSA funding in 2003 to support the system of care efforts through the Transitions project in St. Louis City and St. Louis County. These federally funded sites provide a rich environment to learn what is needed to support true service integration at the community level. In 2005 both sites will pilot a nationally recognized model for developing individualized care plans. Their efforts will help inform the CSMT workgroup as it develops guidelines for implementing evidence-based practice statewide.

Quality Management

Quality Service Review

Missouri's child-serving agencies selected Quality Service Review (QSR) as the process to measure quality and evaluate the effectiveness of services for the children's mental health system of care projects developed around the state under the System of Care Grant (SOC).

QSR is a tool to measure the quality of interactions between frontline practitioners and children and their families and the effectiveness of the services and supports provided. QSR is critical to the project's ability to track progress and make adjustments. . Approximately 60 individuals from the various child serving agencies including Department of Mental Health, Department of Social Services, Department of Health and Senior Services, Department of Elementary and Secondary Education, as well as parents of children receiving services from these departments have been trained as qualified reviewers for the QSR. To date, six of the local SOC sites have completed their initial QSR process. These reviews involved approximately 47 children at the six sites. An aggregate report based on the six sites that have been reviewed will be completed by end of January 2005.

Missouri Juvenile Justice Information System (MOJJIS)

The Missouri Juvenile Justice Information System (MOJJIS) was created to bring the juvenile divisions of the circuit courts and various state agencies into compliance with the Juvenile Crime Bill. The juvenile divisions of the circuit courts and the departments of social services, mental health, elementary and secondary education and health and senior services share information regarding individual children who have come into contact with, or been provided services by the courts and departments. MOJJIS was formalized through a memorandum of understanding between the courts and state agencies.

Next Steps

Developing a unified, comprehensive children's mental health system that provides a full array of services across developmental stages will require significant changes: in policies and state infrastructure; changes in the way the system is managed; and changes at the service delivery level. Effective management of a complex change

process requires careful attention to sequencing and a mechanism for making mid-course corrections. The process will necessarily be incremental, as resources are shifted or expanded and capacity develops. To reflect the complexities involved in a change of this magnitude, the Plan reflects a five year transition plan for the creation of the necessary service capacity, infrastructure and management mechanisms. As described in the Plan (page 13), the period from FY2005 through FY2006 focuses primarily on planning and transition activities necessary to support long term system change in four major areas:

Policy and state infrastructure

Identify legislative and budget issues: Over the next year legislative and budget items needed to support system reform efforts will be identified within each of the work groups created by either the CSMT or the Stakeholder Advisory Group and reported to the Department Directors.

System Management and Improvement

Comprehensive System Management Team: The existing CSMT membership has been expanded to meet the requirements of the legislation. During 2005, four workgroups will be created under the direction of the CSMT to continue addressing the recommendations generated in the planning workgroups. Workgroups include: financing; workforce development; evaluation and quality assurance; and evidence-based practices including the individualized care plan process.

Stakeholder Advisory Committee: The Stakeholder Advisory Committee will be established as described in the Plan (page 24). The first task of this group will be to develop by-laws and operating procedures. Four standing committees will then be created to ensure the following critical functions are addressed:

- Public Education of Missouri citizens, especially families on the importance of mental health, issues of mental and emotional disorders and how to access the system, if needed.
- Monitoring both the activities initiated in response to the various legislation concerned with custody relinquishment and activities related to development of a comprehensive children's mental health system. As a first step, this committee will review the recommendations developed by the Implementation of Child Welfare/Mental Health Reform Workgroup.
- Family Participation. The Plan calls for family participation at all levels of the system. Effective family participation requires a range of support activities and resources. A committee comprised of family members and other stakeholders will develop recommendations on what is needed to ensure this critical component of the system.

- Cultural competency: Missouri is a diverse state and values the unique differences of its people. Ensuring that the system develops in ways that best honor and work within this diversity is vital and complex work that can not be an afterthought. Therefore a standing committee will be created responsible for providing oversight and guidance regarding cultural competency.

Changes at the Service Delivery Level

Communication Plan:

- Providing information and education to the citizens of Missouri, including families and local service providers is a core component of the Plan. A plan detailing communication efforts regarding Senate Bill 1003 and planning activities has been developed. An initial step to creating change at the service delivery level is to increase awareness. A basic presentation package will be developed on SB1003 and the Plan to be used by staff and Stakeholder Advisory Group members to increase awareness within communities. A video showing department leadership working in partnership will be included to stress the point that this is not just a mental health initiative but a jointly shared plan.
- As schools are a door for many children in need of mental health services, it is essential to create a mechanism for communication and training between the local school systems and the state interagency partnership which includes DESE. To begin this dialogue a state summit will be held during FY006 focused on the mental health needs of children in school.

Relinquishing Custody: work will continue on addressing the immediate issues identified in SB 266, HB923 and SB1003 regarding relinquishing custody.

- Diversion Protocols: statewide implementation of the protocols will continue and be monitored.
- Returning Children to Custody of their Parents: Family Support Teams will continue to be convened as children are identified.

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